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**Committee against Torture**
**Sixty-third session**

**Summary record of the 1620th meeting**
Held at the Palais Wilson, Geneva, on Wednesday, 25 April 2018, at 3 p.m.

*Chair*: Mr. Modvig

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*The meeting was called to order at 3 p.m.*

**Consideration of reports submitted by States parties under article 19 of the Convention** (*continued*)

*Eighth periodic report of Norway* (*continued*) (CAT/C/NOR/8; CAT/C/NOR/QPR/8)

1. *At the invitation of the Chair, the delegation of Norway took places at the Committee table.*

2. **Ms. Drazdiak** (Norway), replying to questions raised at the 1617th meeting, said that the Government had not received any information to indicate that Norwegian members of the International Security Assistance Force serving in Afghanistan had participated in any alleged mistreatment or degrading or inhuman treatment. The National Human Rights Institution was an independent body that reported directly to the parliament. Its budget, which was State-funded, had increased significantly since its establishment, rising from 3.3 million Norwegian kroner (Nkr) in 2015 to Nkr 20.6 million in 2017. The national preventive mechanism had undertaken a number of visits to mental health institutions; any incorrect interpretations of the Mental Health Act or wrongful practices it found were communicated appropriately. For instance, following once such visit, the Directorate of Health had written to all psychiatric institutions with instructions on the correct use of restraints.

3. **Mr. Austad** (Norway) said that an increase in prison capacity and the introduction of new guidelines and procedures had resulted in a significant reduction in the use of police custody cells to hold detained persons beyond the 48-hour period allowed by law. While in previous years, a significant number of people had been held in police custody cells for several days at a time, the 48-hour rule had been breached on just 639 occasions in 2017. In 625 of those cases, the limit had been exceeded by one day and in the remaining 14 cases, by two days. As a result, the harmful effects of de facto isolation had also been reduced, although it should be pointed out that the data did not take into account the time spent outside the cell.

4. Amendments to the current regulations on the use of police custody cells required police officers to continuously monitor detained persons to check whether they needed to spend time out of the cell or, if conditions allowed, in the company of other prisoners, which helped to mitigate the effects of isolation. In the light of the updated regulations, the Directorate of Police had created a new instruction manual, which took account of recommendations made by national and international human rights bodies, with the aim of guaranteeing respect for the human rights of persons detained in police cells and ensuring consistency of approach in police stations nationwide. The manual represented a major improvement in how persons detained in police custody were to be treated and contained detailed instructions on access to health care, notification of arrest and the use of video surveillance, among other aspects. Most notably, it required officers to maintain comprehensive records of detention, including how often people had been offered food or the chance to spend time outdoors, thereby enhancing the information available to the relevant monitoring bodies.

5. **Ms. Norderhaug Ferguson** (Norway) said that, pursuant to the Penal Code, which had been amended in 2012, the preventive detention of minors could only be ordered in "wholly extraordinary circumstances". By way of example, in February 2017, the Supreme Court had upheld the preventive detention of a girl who had been 15 years old at the time she had committed a homicide. The Court concluded that the "wholly extraordinary circumstances" threshold had been met, citing the premeditated nature of the homicide, previous violent acts she had committed and her mental state as important factors justifying the use of preventive detention.

6. Referring to paragraphs 26–36 of her country's eighth periodic report, she said that, in the vast majority of cases, the complete or partial exclusion of a person deprived of liberty from the company of other prisoners was used as a means of preventing unwanted or unlawful behaviour. Exclusions as administrative sanctions were used in just 25 per cent of cases. The complete exclusion from the company of other prisoners, as provided for in Norwegian law, was distinct from the definition of isolation or solitary confinement used in

international standards. Complete or prolonged exclusion did not necessarily constitute isolation or solitary confinement, since the persons deprived of liberty could still have meaningful human contact with prison officers, while benefiting from a range of suitable activities, including work and education, and spending two hours outside their cell every day. Every effort was made to keep the use of prolonged exclusions to a minimum and, in 2017, only 31 such exclusions had lasted for more than 42 days. It should be pointed out, however, that such measures were often taken at the request of the person concerned. Although prison staff were required to encourage prisoners to socialize with other prisoners, they could not force them to do so against their wishes. Certain steps could be taken to try to improve the situation, such as moving the person in question to another wing or to a different facility. In some cases, the person was determined to be excluded, leaving no other viable option. In all events, pursuant to the Execution of Sentences Act, prison health-care professionals were immediately informed of any exclusions. They were responsible for conducting a medical assessment of the prisoner's needs and deciding whether daily monitoring by a health professional was required. In any case, prison staff checked on all prisoners who were in exclusion several times a day.

7. Measures to prevent the detrimental effects of exclusion or the exacerbation of existing mental illnesses included providing the excluded prisoner with additional time outdoors, physical activities, visits from friends and family and extended time in the company of prison staff. No data were collected on the number of cases in which medical personnel had recorded negative health effects for prisoners subject to complete exclusion or had recommended that their exclusion should be discontinued. The guidelines on the use of exclusions had been revised in March 2017 to ensure that all de facto exclusions were properly recorded and to provide staff with detailed information on interpreting the related legislation. That was why the data had showed an increase in the number of complete exclusions. The number of partial exclusions had actually decreased from 2,566 in 2016 to 1,920 in 2017, while the average length of complete exclusion had fallen from 3.9 days to 3.4 days in the same period. Since the guidelines were in the process of being implemented, no impact assessment had as yet been undertaken.

8. Under the Public Administration Act, prisoners could file complaints about the use of exclusions, although they were not heard until after the exclusion had been implemented. The relevant appeal body could give priority to certain cases if it was deemed necessary. The grounds for exclusion would be assessed and, if they were found no longer to apply, the exclusion could be repealed. In 2017, 50 complaints regarding prisoner exclusions had been filed at the regional level, of which 3 had been overturned; at the central level, 7 cases had been filed and 2 had been overturned. Apart from the case brought by Anders Breivik, the authorities were not aware of any complaints of prisoner exclusion that had been tried in the courts. However, plaintiffs could apply for free legal aid to help cover the associated court costs, if necessary.

9. As far as the case of Anders Breivik was concerned, in March 2017 the Court of Appeal had ruled that his detention conditions were not in violation of article 3 of the European Convention on Human Rights. Among other aspects, the Court considered that his prolonged isolation and the use of other security measures were necessary owing to the imminent risk of violence he posed to other prisoners; that the conditions in which he was being held were of a higher standard than those of other inmates; and that the measures in place to mitigate the negative effects of isolation were adequate and adapted to his needs. It also stated that, in the near future, the possibility of limited contact with prisoners should be assessed and eventually tried out under strict controls. The plaintiff had subsequently submitted an appeal to the Supreme Court, which had been rejected, and he had now taken his case to the European Court of Human Rights. In the meantime, his prison conditions remained largely unchanged and an evaluation conducted on 12 April 2018 had found no signs that his continued exclusion had had any harmful effects. Limited contact with other prisoners had yet to be attempted, since it was difficult to find prisoners to whom he posed no threat or who would not face consequences from other inmates.

10. In the light of the findings of the 2015 Cramer report, which had highlighted the fact that persons deprived of liberty were at greater risk of mental health problems, various measures had been taken to prevent the suicide of prisoners, strengthen basic and

specialized education for prison staff on mental illness and substance abuse and increase the range of activities available to vulnerable groups to mitigate feelings of isolation. At the Ila prison facility, the exclusion of a small number of prisoners who had severe mental illnesses was based on the fact that they had often exhibited violent behaviour that put other prisoners and prison staff at risk. However, various initiatives had been put in place in an effort to improve their conditions. For example, a team had been established in 2014 to introduce meaningful activities and reduce the use of prolonged exclusion. Some improvements had been noted and an evaluation was under way to determine whether to continue and further reinforce that team's mandate or try a different approach. Other measures included increasing staff levels, enhancing capacity-building and creating a secure community unit where those prisoners could socialize with others. The Ministry of Justice and the Ministry of Health were currently awaiting a report from Correctional Services regarding other measures taken. Further ways to improve the treatment of prisoners with mental health or substance abuse issues would then be discussed.

11. Emphasis had been placed on suicide prevention in the education and training of prison staff, including on how to identify vulnerabilities and risks related to imprisonment and ensure that persons deprived of liberty maintained human contact and established routines. In the event of imminent danger of a suicide, health personnel provided assistance. The preference was always for the prisoner to be transferred to a psychiatric institution, if the circumstances allowed. If not, then prison staff had no other choice but to use exclusion or security cells or beds if doing so would prevent a suicide.

12. The leasing of Norgerhaven prison in the Netherlands had been a temporary solution to deal with the queue of convicted persons waiting to serve their sentences. Prison capacity had now been increased and a new prison was due to open in 2020; thus, the agreement with the Dutch authorities would not be renewed when it expired on 31 August 2018. If extra capacity was required, the "double-bunking" of prisoners would be used as an interim measure. It was worth pointing out, however, that the Government wholly disagreed with the assessment of the national preventive mechanism that prisoners transferred to Norgerhaven prison were not adequately protected from torture and inhuman or degrading treatment. The Netherlands was a party to all relevant international conventions, including the Convention against Torture, and all acts of torture were prohibited under Dutch law. The leasing agreement and accompanying cooperation agreement clearly defined the responsibilities of both parties in ensuring respect for the prisoners' human rights. Moreover, the Norwegian authorities were in charge of the administration of the prison and monthly meetings were held with the Dutch public prosecutor to discuss how to deal with any criminal acts committed in the prison. According to a survey of those prisoners, they had experienced a relatively good quality of life and, in particular, had been able to maintain contact with friends and family via Skype, something that was not always possible in Norwegian prisons. Lastly, many of those prisoners were not, in fact, Norwegian citizens and were actually closer to their homes while at Norgerhaven prison than if they had been imprisoned in Norway.

13. **Ms. Hellevik** (Norway) said that the Government had explicitly stated in its January 2018 platform the intention to strengthen mental health services for prisoners and reduce the number of individuals with mental health problems in the penitentiary system. One of the means of achieving that goal had been to place persons caught in possession of illicit substances for personal consumption in mental health institutions rather than police custody. Similarly, a 2016 amendment to the General Civil Penal Code required that persons deemed to have been psychotic at the time of the offence and therefore not criminally responsible should be placed in a psychiatric institution instead of prison. The amendment applied not only to murder and serious violence but also to less serious but repeated offences.

14. Persons deprived of their liberty, including those in police custody, enjoyed the same right to health services as the rest of the population. Municipalities were responsible for the provision of primary health care in prisons, while secondary and specialist care came under the purview of the regions. The Government awarded annual health care grants to municipalities with prisons in their territory. The Norwegian Directorate of Health and the Directorate of Norwegian Correctional Services had set up a working group in follow-up to the Cramer study. On the basis of the working group's report, the Directorate of

Health had made recommendations to the Ministry of Health on the organization of mental health services for prisoners, including that such services should be made a specialized function of psychiatric and drug rehabilitation facilities and that specially-trained professionals should work in polyclinics inside prisons. The latter recommendation had already been implemented in a number of locations.

15. Regarding the group of isolated prisoners at Ila Detention and Security Prison, it should be noted that the Government had allocated an additional NKr 10 million for health care, which had been used to recruit a psychologist and specially trained guards. The prison cooperated closely with the local mental health-care institution and the forensic unit, which would be replaced with a modern facility in the coming years. Decisions on the need for coercive measures, such as isolation from other inmates, were taken by the correctional authorities. However, health-care professionals should be consulted when there were doubts about the mental health of the person concerned. The revised guidelines on prison health services — which all health-care professionals were expected to be familiar with and adhere to — focused on isolation and stipulated that health-care professionals should visit isolated prisoners daily. No data were available on the extent to which that instruction was followed. In March 2018, the Directorate of Health had invited prison health-care staff to a national dialogue, including on the topic of isolation, which was expected to become an annual event. In addition, the Directorate produced an annual report on the state of health care in prisons.

16. **Mr. Austad** (Norway) said that it was difficult to measure the impact of the steps taken in the area of violence against women and children. Nevertheless, one positive outcome would be a rise in the number of reported cases, which was expected to occur as a result of measures to facilitate the reporting of cases, such as authorizing police officers who responded to domestic incidents to report them. Furthermore, the Sami parliament had been paying closer attention to the issue since research had shown gender-based violence to be more prevalent among the Sami population. A study had been conducted on violence against older persons in 2017, which would serve as a baseline for subsequent iterations.

17. Efforts were continuing to better prevent rape and punish its perpetrators. Penalties had been significantly stiffened, in particular in the case of rape against a person who was unable to resist, which now carried a sentence of 3 to 4 years' imprisonment compared to only a few months, and a new plan of action was to be finalized in 2018. In addition, steps were being taken to encourage victims to report cases. There were numerous reasons why cases did not lead to indictments or convictions, including the lapse of time between a rape and its reporting and the lack of forensic evidence. In 2016, a team of experienced prosecutors had conducted a systematic review of a representative sample of 280 rape cases. The various stages of each investigation were scored based on nearly 100 quality indicators developed by the prosecutors. The results had been very encouraging, especially with regard to interviews by the police. There was still room for improvement, however, for instance by asking victims extra factual questions to corroborate their statements. A decision had been taken to do away with juries in appellate courts after a number of convictions in rape cases had been overturned. The effects of that decision in practice remained to be seen.

18. **Ms. Hellevik** (Norway) said that the Government had strived over the past 20 years to set up more accessible and comprehensive mental health services, including 150 mobile outreach teams, so that people could remain in their communities. Those efforts had gone hand in hand with a shift from inpatient to outpatient treatment. Moreover, there had been a drop in the need for hospitalization, including forced committals. It was the view of Norway that it was possible to resort to coercion less frequently by adopting a more comprehensive and respectful approach to patient care. Thus, considerable effort was being made to improve legislation and reporting, enhance skills and tackle attitudes.

19. While it was the responsibility of the health trusts to ensure that coercive measures were applied lawfully, the Ministry of Health had stepped up its monitoring of the trusts. In 2017, the trusts had been required to hold dialogues with patients and user organizations about how patients experienced coercion. Furthermore, since 2016, the trusts had been required to offer medication-free treatment options, including to persons with serious mental illnesses. The programme, which had garnered a fair amount of international interest,

would be evaluated soon. In a shift from a purely medical to a more functional approach, the Mental Health Care Act had recently been amended, in part on the basis of concerns expressed by user organizations, in order to prohibit the forced hospitalization or treatment of persons who had the capacity to consent unless they posed a danger to themselves or others. In addition, patients were eligible for up to five hours of free legal counsel in the event of involuntary treatment and the competent mental health professional was required to consult with another qualified health-care practitioner, ideally someone who had a longstanding relationship with the patient, before making a decision on involuntary treatment. The appropriateness of the capacity to consent criterion would be evaluated in 2018 with the aim of developing an e-training programme for mental health professionals on how to assess a person's capacity and of determining whether the amendment was contributing to the reduction of involuntary treatment.

20. In 2017, the Government had released additional funds to strengthen the 55 mental health care supervisory commissions, a portion of which would be spent on developing an e-training course on coercive measures. The course, which would take into account user views, was intended for health-care practitioners and appellate bodies. In addition, a national conference for commission heads had been held and a super commission had been set up to support the commissions in response to the national preventive mechanism's finding that they were underperforming.

21. The quality of data on involuntary treatment and coercive measures had improved since 2015 owing to a Ministry of Health requirement that hospitals should report accurately on their recourse to such measures and the establishment of a new set of national indicators. There were still no data on the duration of measures; however, that was expected to change once the Directorate of Health had set standards for the inclusion of measures in electronic medical records. The latest statistics on coercive measures were expected to be published in the coming days and would, for the first time, provide reliable figures on the involuntary placement of children.

22. The Government had appointed a legislative committee to review the rules on the use of coercive measures in all health-care facilities. The committee's remit was to assess how to clarify and coordinate the rules and possibly group them into a single law, establish whether certain provisions needed to be brought into line with human rights law, consider assisted decision-making mechanisms and determine whether the criteria permitting the use of coercive measures were sufficiently strict.

23. One of the priorities of the Directorate of Health was to develop, in conjunction with user organizations, guidelines on mental health care and the treatment of drug addiction by the end of the year. A similar initiative in relation to cancer was credited with providing patients with prompter care, more information and greater predictability.

24. **Ms. Din** (Norway) said that persons with disabilities enjoyed the same right to have children as others. However, there was a law that provided for abortion or sterilization in cases where the woman was unable to give her free and informed consent. A legal guardian could apply for either of those procedures on behalf of a woman with a serious mental disorder or intellectual disability. Such applications were granted only if the woman was unable to understand the significance of the pregnancy and the procedure was in her best interest. Decisions in such cases were taken by the county governor or a board, depending on the procedure being requested. Only one application for sterilization had been granted in 2017.

25. **Mr. Roed** (Norway) said that people who had suffered an injury or whose health had been impaired as a result of a violent crime might be eligible for criminal injury compensation, as could the dependants of a person who died as a consequence of a violent crime or those who witnessed violence towards close relatives. As a rule, compensation was awarded only if the injury was sustained in Norway, though exceptions could be made for incidents occurring abroad that involved habitual residents of Norway. In 2017, 12 victim support offices had been set up in police stations to provide advice, referrals and practical support, including on the preparation of applications for compensation. Victims of criminal offences were entitled to legal assistance and information and enjoyed the right to take part in every stage of proceedings. Persons who sustained injuries due to failings of the

Norwegian health-care system could claim economic compensation. There was no application fee, and those who were too ill to manage their case were granted the lawyer of their choosing free of charge.

26. In principle, asylum seekers were not detained; rather, they lived in reception centres and enjoyed full freedom of movement. Children could only be detained in the context of deportation. The police could request detention only if there was a significant risk of absconding or if the parents had actively opposed forced return and deportation was imminent. Families were held in special facilities, typically for no more than three days. There were only a few cases per year of children being detained for longer than 72 hours.

27. **Ms. Din** (Norway) said that the asylum interview would seek to detect whether a refugee had been subjected to torture. Arrival centres were equipped with medical health personnel such as doctors and nurses. Full medical examination, as foreseen under the Istanbul Protocol, took place once the refugee had been moved to a long-term reception centre. That examination should take place within 90 days from arrival in Norway. The Government believed that it was better if persons were settled in their permanent place of residence prior to the examination. Regional resource centres provided training for the health personnel responsible for examinations. The Government was aware of its responsibilities to provide care for victims of torture and ill-treatment, including to asylum seekers, who had the same access to health care as permanent residents. A centralized psychosocial centre for treatment of traumatized refugees would not be suitable in Norway, due to the country's particular topography. The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) and the five regional resource centres fulfilled that role. The centres had teams specialized in refugee health who provided guidance to regional and municipal health services in detecting and treating victims of torture.

28. **Mr. Austad** (Norway), responding to the Committee's questions concerning the Trandum holding centre, said that Trandum was the only centre of its kind in Norway and was not comparable to other institutions in the country. Its mandate did not include the processing of asylum seekers. Inspections carried out by the Parliamentary Ombudsman and the national preventive mechanism had led to positive developments at the centre. However, the level of frustration among the inmates, many of whom were detained there prior to deportation, was high. The mix of long- and short-stay detainees also presented challenges for staff. That had caused unrest at the centre. It was thus necessary to find a balance between the need to maintain order and that of safeguarding the welfare of inmates. Handcuffs were frequently used during transport to court hearings, but specifically when the staff did not know the detainee being transported, who might be a new arrival at the centre.

29. Pepper spray had been used in one isolated incident, in the case of a highly disturbed individual. The decision to transfer an individual to a security ward at Trandum rested entirely with the police, not with the doctors. Such transfers were always preventive, never disciplinary, and could lead to improved care of the inmate, allowing freer dialogue between him or her and the staff than in a ward with many others present. Transfers to the security wards were not made when they ran the risk of worsening a mental health condition, in compliance with the Nelson Mandela Rules. The police was considering the establishment of a special unit for inmates with certain mental problems. A discrepancy had been noted between the period of detention at Trandum given in paragraph 122 of the Government's report and the national preventive mechanism's findings given in paragraph 123. That was due to riots at the centre prior to the national preventive mechanism's May 2015 visit, which had resulted in delayed departures of inmates and thus altered the figures. Conditions for long-term inmates were improving at Trandum with the provision of priority access to health services and a range of special activities to cater for their needs. The national preventive mechanism had criticized Trandum for its use of private health service providers and recommended ceasing that practice, which could give rise to independence issues. The Government believed that health services provided by the municipality would not be better, but that question would be raised with the Subcommittee on the Prevention of Torture when it visited Norway in 2018.

30. **Mr. Roed** (Norway) said that free legal aid was provided in civil law cases for the types of cases set out in the Legal Aid Act. In criminal cases legal aid was regulated by the

Criminal Procedure Act. Under criminal procedure, the defendant was entitled to a public defence counsel during the main hearing. During investigation and prior to the filing of charges, legal aid was normally only provided when there were special grounds, such as if the defendant's physical or mental condition indicated specific need for defence counsel.

31. **Ms. Drazdiak** (Norway), replying to a question concerning detention of asylum seekers, said that the clear basis was that asylum seekers were not detained. They could be lodged in a reception centre, or find private accommodation, and enjoyed full freedom of movement. The Police assessed each case according to strict criteria, ascertaining whether less intrusive measures than detention should apply. Detention might be used where foreign nationals' requests for asylum had been denied, or in cases of deportees returning to Norway. It might also be used where there was a risk of persons absconding, or in cases of uncertain identity. Safeguards, other than the assessment criteria, included regular checking by the courts that conditions for detention were met, and that return procedures were progressing properly.

32. **The Chair** said that the delegation's reply to the Committee's question regarding aligning the definition of torture with that in the Convention and incorporating the Convention into national law had merely repeated the reply given in the report. The Committee would welcome constructive dialogue in that field.

33. Sections 291 and 297 of the Norwegian Penal Code gave differing sanctions for rape. Moreover, the definition of rape in Section 291 — the main section dealing with rape — was not in line with the definition given in article 36 of the Istanbul Convention, recently ratified by the State party. That meant that some rape cases in Norway could fall under Section 297, and lighter sentences would be handed down accordingly. The Committee recommended that the Penal Code's definition should be aligned with the Istanbul Convention.

34. The delegation had intimated that unaccompanied minors mostly absconded voluntarily from reception centres. The Committee wished to know whether some disappearances might not be due to conditions pertaining in the centres and whether those were worse than in ordinary child welfare institutions, which were not subject to such absconsion. Should that prove the case, consideration might be given to extending the responsibility of child welfare institutions to include refugee children. The Committee understood that police were involved in the transport of children to the child welfare institutions. It would like to know whether that was a common practice and how it was regulated. In respect of limiting the possibility of preventive detention of minors, the Committee wished to know whether the Execution of Sanctions Act, of which article 37, paragraph 5, limited such detention to a maximum of 7 days, had entered into force.

35. Electroconvulsive therapy (ECT) should not be used without free, informed consent. The Committee asked the Government to ensure that the law prohibiting serious interventions except medication and nutrition was fully respected by health professionals. Statistics showing the extent of recourse to ECT without consent would be welcome.

36. In respect of detention in police stations, which amounted to de facto solitary confinement, the Committee asked whether the Government might consider setting an absolute deadline of 48 hours, with no exceptions. Current practice in Norway was to have prison guards assess the mental health of those detained in police custody. That raised the general question of the State party's level of adherence to the Nelson Mandela Rules, and the Committee questioned whether the arrangement was sustainable.

37. In cases of solitary confinement the Nelson Mandela Rules stipulated that detainees should receive visits from health-care staff on a daily basis. Norway placed responsibility for that on medical doctors. The Committee wished to know what and how information was made available to the doctors to enable them to make the assessment. The responsibility for the health of prisoners should be not with doctors, but with the criminal justice authorities, and the Committee would appreciate more information on how the daily visits, which the delegation had said took place, were organized.

38. With regard to the 426 severely mentally ill persons detained in Ila prison, the delegation had provided welcome information explaining that those persons were being

transferred to mental health institutions. The Committee wished to know how many had so far been transferred and how advanced implementation of the transfer policy was. It welcomed the news of the projected polyclinic to be built in the vicinity of Ila prison to provide additional support, but wished to know whether allowance had been made for conducting forensic medical examinations on prisoners who had been assessed as accountable when first detained, but whose mental condition had subsequently deteriorated.

39. The Committee welcomed the information that Norway had improved its assessment and prevention modalities regarding the risk of suicide. It wished to know whether the assessment was confidential, private and carried out by health personnel. The preferred approach in cases of suicide risk was through use of a psychiatrist, but the Committee would be grateful for statistics and information regarding the use of security cells.

40. The Committee welcomed the information that the investigation procedure for rape cases had been improved and that it had received high approval ratings, but did not agree with the Government that the victim's assessment was not relevant. It might be the case that the victims were not well received in the police stations, and faced a high level of doubt when making their allegations. In those cases, the victims' assessment of the procedure would be very valuable.

41. The Committee thanked the delegation for the information regarding the contractual health care arrangements in Trandum, but wished to clarify its initial question, which was whether the medical staff, were it public or privately supplied in Trandum or elsewhere, was sufficiently prepared for dealing with persons in restraint, in a security cell or in isolation. Those situations could pose ethical problems for doctors whose first line of duty was to the well-being of the patient.

42. **Mr. Hani** said that he noted the explanation given by the delegation that the discrepancy in the figures for periods of detention at Trandum as set out in paragraphs 122 and 123 of its report was due to the prison riot in May 2015 delaying prisoners' departures. However, the discrepancy was so great that the explanation appeared inadequate. The Committee would therefore welcome more precise figures for detention periods. No response had been made to the Committee's request for information on the administrative investigations carried out following the deaths that had occurred in prison cells or following police intervention described in paragraphs 110 to 114 of the Government's report. Similarly, with regard to the statistics provided regarding complaints from 2012 to 2015 investigated by the Norwegian Bureau for the Investigation of Police Affairs, no information on the types of sanctions, correlated with the type of offence committed, had been included. The figures showed that complainants only had a 2 per cent chance of success in such legal action, which would discourage the filing of complaints. The Committee would like to receive further information in both those areas and the delegation could avail itself of the additional 48-hour time allowance to supply that information.

43. In relation to the issue of unaccompanied minors absconding from reception centres, the point at which an individual's age was taken into account by the authorities was significant. If their age at the time of the examination of their asylum application prevailed over their age at arrival on the territory, those approaching 18 years of age might leave because the protections afforded to them as minors were coming to an end.

44. The practice of only offering asylum seekers a medical examination after three months deprived some individuals of the chance to use their medical file in support of their asylum application. Medical examinations should therefore be offered as soon as possible, not after 90 days. He wondered what measures the State party was taking to address the problems mentioned in paragraph 158 of the State party's report, particularly the refusal of health personnel to examine asylum cases because of a lack of cultural knowledge.

45. While he was pleased that the Norwegian authorities had decided to discontinue the practice of transferring prisoners to Norgerhaven prison, he would welcome an explanation for the very high percentage of foreign inmates transferred and why high numbers of inmates had been transferred against their will. He invited the delegation to provide assurances that the 48-hour time limit for the interrogation of arrested persons comprised the full period of their custody, including time spent outside a police cell.

46. As official statistics pointed to a 300 per cent rise in the number of cases of detained persons receiving forced medical treatment between 2014 and 2015, the State party was encouraged to begin taking steps to reduce its recourse to forced medication as soon as possible. The State party might draw useful lessons from the article of investigative journalism that had exposed unacceptable levels of solitary confinement in Bergen prison, and the related television documentary that had subsequently been broadcast. He would welcome further details on the use of ECT in Norway. Lastly, he looked forward to receiving written replies to his questions regarding the State party's support of the United Nations Voluntary Fund for Victims of Torture and the development of a set of standards for non-coercive interviewing methods as proposed by the former United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.

47. **Ms. Belmir** said that she wished to emphasize the importance of conducting investigations into cases of disappearances of unaccompanied minors, given their vulnerability to falling victim to human trafficking. She would also welcome further details about the circumstances in which the State party imposed custodial sentences without a date of release.

48. **Ms. Gaer** asked whether the State party had conducted any studies into ECT, which she understood was used in Norwegian detention facilities in cases of depression and psychosis as well as in emergencies. She sought clarification on whether the planned return to Norway of the inmates held in the Norgerhaven prison was expected to lead to overcrowding in Norwegian detention facilities. The State party had not yet answered her earlier question regarding whether having a facility in another country had helped it to meet its obligations under the Convention.

49. She asked whether the delegation could offer any explanation for the continued high incidence of rape in Norway. In a recent newspaper article, a senior member of the public prosecution service had attributed the high rate of acquittal in cases of sexual violence to failures to conduct thorough investigations, and claimed that increased efforts would lead to more indictments. Did the delegation agree with that assessment? She would welcome information on whether training on sexual violence was provided in the police training academy, and whether any public official had been prosecuted for failure to properly investigate a case of sexual violence.

50. **Mr. Hani** said that, while he welcomed the State party's efforts under the Mental Health Act to provide for a second medical opinion in mental health assessments, that opinion should be provided by a specialist psychiatrist, not an attending physician or nurse.

*The meeting was suspended at 5.25 p.m. and resumed at 5.35 p.m.*

51. **Mr. Austad** (Norway) said that the disappearance of unaccompanied minors had been a complex and challenging issue for many years, though the problem had reached its peak in 2017 following the unusually large number of minors who had arrived in 2015 and 2016. Staying at reception centres was voluntary even for minors, and a large number of them left to seek asylum in other countries. Where the authorities had reason to believe that a minor could be a victim of trafficking, provisions were in place for their detention in a special institution pending further assessment. It was true that many individuals left because they were approaching 18 years of age and were thus facing a possible forced return to their country of origin. In order to avoid disappearances of unaccompanied minors, the Government had allocated supplementary funding to improve the quality and number of staff in reception centres. It had also taken steps to regularize the situation of unaccompanied minors who had a limited residence permit owing to doubts about their identity.

52. There had been no deaths in police custody in Norway in 2016, and only one at the end of 2017, which was still under investigation. In 2016, 1,188 complaints had been made to the Norwegian bureau for the investigation of police affairs, of which 45 per cent had been dropped without investigation, while 29 per cent had led to criminal sanctions. In 2017, 970 complaints had been recorded, of which 49 had been dropped without investigation and 29 per cent had again led to criminal sanctions. Cases were only dropped without investigation after an interview with the complainant and the consultation of any relevant police records. Priority was given to cases concerning allegations of racism, but

those were few in number. There were no plans to record the ethnicity of complainants for statistical purposes. Following a working group recommendation issued in 2014, all cases referred for administrative assessment in the various police districts from 2014 onwards would be subject to review.

53. **Ms. Norderhaug Ferguson** (Norway) said that the Government agreed that the isolation of children should be prohibited as a disciplinary and preventive measure and had enacted legislation to that effect. However, section 37 (5) of the Execution of Sentences Act, which would limit the use of the full exclusion of minors to seven days, had not yet entered into force as it presented practical challenges: in one recent case, it had been necessary to maintain the segregation of an imprisoned girl for longer than seven days for reasons of safety. It was important to be aware that full exclusion, as described in the Act, was not tantamount to solitary confinement or isolation; the girl in question had been segregated from other prisoners but had continued to receive meaningful human contact and health care, including psychiatric attention at a ward located outside the prison. The relevant legal provision would be amended so as to limit the use of de facto isolation of minors while allowing for acceptable practical solutions for exceptional situations.

54. She agreed with Mr. Hani that the media focus on mentally ill prisoners had been useful for identifying improvements to be made. The television programme to which he had referred had led to action at all levels of the Norwegian justice and health care sectors.

55. **Ms. Hellevik** (Norway) said that, beginning in 2019, all hospitals would have to report how many treatments they administered without the patient's consent. Around one thousand ECT treatments were administered per year; although it was not known how many were lifesaving, a committee had been appointed to assess the use of the treatment and would deliver a report in summer 2019. The Directorate of Health was about to begin collecting statistics on the number of ECT treatments administered without consent. Depressed or suicidal patients could always refuse the therapy, which was only contemplated after less invasive treatments had been ruled out.

56. **Mr. Roed** (Norway) said that the Directorate of Immigration always asked asylum applicants if they had health problems before their asylum interview. Applicants who claimed to be victims of torture were encouraged to document their injuries by obtaining a medical certificate from the public health or mental health services. The Directorate was aware that the vulnerability of torture survivors could affect the information they provided in their interview. It informed applicants about how to access medical care in Norway, and provided for special accommodations in reception centres if necessary.

57. The education programme of the police university college was continually being revised. Sexual violence had been a compulsory topic of study since 2016. Complainants who were dissatisfied following the acquittal of a person accused of a sexual offence could complain to the supervisory committee for judges, which did not have the power to overrule the judicial decision per se, but could assess such matters as the length of the proceedings and the judge's behaviour. The committee could impose disciplinary measures in the form of criticism and warnings.

*The meeting rose at 5.55 p.m.*